		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010330

Facility Name: Rehab & Care Center-Jackson County

Address: 1441 North 14th Street (Number) Murphysboro (City) 62966 (Zip Code)

County: Jackson

Telephone Number: 618-684-2136 **Fax #** 618-684-5710

IDPA ID Number: 37-6001092-004

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mark Dallas **Telephone Number:** 618-529-1040

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/99 to 11/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) (Date)

(Print Name and Title) Mark W. Dallas CPA, Partner

(Firm Name & Address) Kerber, Eck & Braeckel LLP
1116 W. Main St.
Carbondale, IL 62903

(Telephone) 618-529-1040 Fax # 618-549-2311

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 260

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	260	Skilled (SNF)	260	95,160	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	260	TOTALS	260	95,160	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,067	2,997	6,437	16,501	8
9	SNF/PED					9
10	ICF	33,180	16,577	985	50,742	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,247	19,574	7,422	67,243	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.66%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5 / / 60

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 54 and days of care provided 6266

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: Fiscal Year: 11/30/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Rehab & Care Center-Jackson County # **Report Period Beginning:** 12/1/99 **Ending:** 11/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	393,125	26,133	13,296	432,554		432,554	0	432,554			1
2	Food Purchase		264,440		264,440		264,440	(495)	263,945			2
3	Housekeeping	393,166	44,544	33,979	471,689		471,689	0	471,689			3
4	Laundry							0				4
5	Heat and Other Utilities			212,801	212,801		212,801	0	212,801			5
6	Maintenance	94,182	31,486	71,412	197,080		197,080	0	197,080			6
7	Other (specify):*							0				7
8	**TOTAL General Services**	880,473	366,603	331,488	1,578,564		1,578,564	(495)	1,578,069			8
	B. Health Care and Programs											
9	Medical Director			37,080	37,080		37,080	0	37,080			9
10	Nursing and Medical Records	2,418,403	73,606	24,575	2,516,584		2,516,584	0	2,516,584			10
10a	Therapy	164,620			164,620		164,620	0	164,620			10a
11	Activities	124,548			124,548		124,548	0	124,548			11
12	Social Services	87,751			87,751		87,751	0	87,751			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Programs**	2,795,322	73,606	61,655	2,930,583		2,930,583		2,930,583			16
	C. General Administration											
17	Administrative	45,691		21,904	67,595		67,595	(21,804)	45,791			17
18	Directors Fees							0				18
19	Professional Services			29,675	29,675		29,675	(15,000)	14,675			19
20	Dues, Fees, Subscriptions & Promotions			18,137	18,137		18,137	(1,065)	17,072			20
21	Clerical & General Office Expenses	160,533	25,222	38,069	223,824		223,824	(2,855)	220,969			21
22	Employee Benefits & Payroll Taxes			1,087,701	1,087,701		1,087,701	(4,756)	1,082,945			22
23	Inservice Training & Education							0				23
24	Travel and Seminar			8,809	8,809		8,809	0	8,809			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			29,732	29,732		29,732	0	29,732			26
27	Other (specify):*							0				27
28	**TOTAL General Administration**	206,224	25,222	1,234,027	1,465,473		1,465,473	(45,480)	1,419,993			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,882,019	465,431	1,627,170	5,974,620		5,974,620	(45,975)	5,928,645			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			316,460	316,460		316,460	(49,114)	267,346			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes							0				33
34	Rent-Facility & Grounds							(2,100)	(2,100)			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			316,460	316,460		316,460	(51,214)	265,246			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		283,111	341	283,452		283,452	0	283,452			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			142,746	142,746		142,746	0	142,746			42
43	Other (specify):*							0				43
44	**TOTAL Special Cost Centers**		283,111	143,087	426,198		426,198		426,198			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,882,019	748,542	2,086,717	6,717,278	0	6,717,278	(97,189)	6,620,089			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(495)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(2,100)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(49,114)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(225)	20		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,804)	17		24
25	Fund Raising, Advertising and Promotional	(840)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,611)	21,22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (97,189)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (97,189)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name Rehab & Care Center-Jackson County

ID#

Report Period Beginning: 12/1/99

Ending: 11/30/00

Print Other Adjustments

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	(495)
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	(495)	2	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	(2,100)	34	Line 6	0
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	0	0	Line 8	(495)
9	Non-Straightline Depreciation	(49,114)	30	Line 9	0
10	Interest and Other Investment Income	0	0	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	0	0	Line 12	0
14	Non-Care Related Interest	(225)	20	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	0	Line 15	0
17	Non-Care Related Fees	0	0	Line 16	0
18	Fines and Penalties	0	0	Line 17	(21,804)
19	Entertainment	0	0	Line 18	0
20	Contributions	0	0	Line 19	(15,000)
21	Owner or Key-Man Insurance	0	0	Line 20	(1,065)
22	Special Legal Fees & Legal Retainers	(15,000)	19	Line 21	(2,855)
23	Malpractice Insurance for Individuals	0	0	Line 22	(4,756)
24	Bad Debt	(21,804)	17	Line 23	0
25	Fund Raising, Advertising and Promotional	(840)	20	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	0	0	Line 27	0
29	Non-Paid Workers	0	0	Line 28	(45,480)
30	Donated Goods	0	0	Line 29	(45,975)
31	Amortization Expense	0	0	Line 30	(49,114)
32				Line 31	0
33				Line 32	0
34				Line 33	0
35				Line 34	(2,100)
36				Line 35	0
37				Line 36	0
38				Line 37	(51,214)
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44	Copies	(125)	21	Line 43	0
45	Postage Income	(41)	21	Line 44	0
46	Auxillary Contribution	(240)	21	Line 45	(97,189)
47	Vending Income	(4,756)	22		
48	Misc. Income	(2,449)	21		
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1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(495)	0	0	0	0	0	0	0	0	0	0	(495)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(495)	0	0	0	0	0	0	0	0	0	0	(495)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(21,804)	0	0	0	0	0	0	0	0	0	0	(21,804)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,000)	0	0	0	0	0	0	0	0	0	0	(15,000)	19
20	Fees, Subscriptions & Promotions	(1,065)	0	0	0	0	0	0	0	0	0	0	(1,065)	20
21	Clerical & General Office Expenses	(2,855)	0	0	0	0	0	0	0	0	0	0	(2,855)	21
22	Employee Benefits & Payroll Taxes	(4,756)	0	0	0	0	0	0	0	0	0	0	(4,756)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(45,480)	0	0	0	0	0	0	0	0	0	0	(45,480)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(45,975)	0	0	0	0	0	0	0	0	0	0	(45,975)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(49,114)	0	0	0	0	0	0	0	0	0	0	(49,114)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,100)	0	0	0	0	0	0	0	0	0	0	(2,100)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(51,214)	0	0	0	0	0	0	0	0	0	0	(51,214)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(97,189)	0	0	0	0	0	0	0	0	0	0	(97,189)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number: Rehab & Care Center-Jackson County | 4 | Report Period Beginning: 12/1/99 | Ending: 11/30/00

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

Sum_6

1 Schedule V	2 Line	3 Cost Per General Ledger: Item	4 Amount	5 Cost to Related Organization: Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		$ -	-	-	$ -	$ -	1
2	V		-	-	-	-	-	2
3	V		-	-	-	-	-	3
4	V		-	-	-	-	-	4
5	V		-	-	-	-	-	5
6	V		-	-	-	-	-	6
7	V		-	-	-	-	-	7
8	V		-	-	-	-	-	8
9	V		-	-	-	-	-	9
10	V		-	-	-	-	-	10
11	V		-	-	-	-	-	11
12	V		-	-	-	-	-	12
13	V		-	-	-	-	-	13
14	Total		$ -			$ -	$ -	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1	Line 2	Line 3	Line 4	Line 5	Line 6	Line 7	Line 9	Line 10	Line 10a	Line 11	Line 12	Line 13	Line 14	Line 15	Line 17	Line 18	Line 19	Line 20	Line 21	Line 22	Line 23	Line 24	Line 25	Line 26	Line 27	Line 30	Line 31	Line 32	Line 33	Line 34	Line 35	Line 36	Line 38	Line 39	Line 40	Line 41	Line 42	Line 43

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 150,000 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	871,200	1960	$ 10,000	1
2					2
3	TOTALS	871,200		$ 10,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	130		1960	1960	$ 1,069,483	$ 32,779	30	$	$ (32,779)	$ 1,069,483	4
5	28		1966	1966	289,003	10,168	30		(10,168)	289,003	5
6	102		1972	1972	1,404,551	51,885	30	51,885		1,344,467	6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 94,832		$ 51,885	$ (42,947)	$ 2,702,953	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Parking Lots			1971	63,650		20			63,650	9
10	Building Improvements			1974	122,761		20			122,761	10
11	Building Improvements			1978	31,978		20			31,978	11
12	A/C / Sprinkler			1979	9,155	41	20		(41)	9,155	12
13	Fixed Equipment			1980	12,129		15			12,129	13
14	Land Scaping/Fixed Equipment			1981	1,557		10			1,557	14
15	Building Improvements			1981	22,832	1,142	15		(1,142)	22,832	15
16	Fixed Equipment/Bldg. Improvements			1982	343,459		15			343,459	16
17	Light Fixtures			1982	1,115		10			1,115	17
18	Sprinkler System			1982	10,660	426	25	426		7,881	18
19	Building Improvements			1983	38,573		15			38,573	19
20	Building Improvements			1983	1,158	58	20	58		1,015	20
21	Roof Repair/Air Handler			1984	122,376		15			122,376	21
22	Fire Alarm/Electrical Improvements			1984	55,767		20	2,790	2,790	46,034	22
23	Storage Garage/Fire Doors/Key Locks/Bldg Improv.			1985	8,232	356	20	412	56	6,386	23
24	Booster Pump			1985	1,085		10			1,085	24
25	Heating System/Fire Alarm System			1985	138,269	9,188	20	6,913	(2,275)	107,152	25
26	Call Light System-Repair & New			1985	22,252	735	15	735		22,252	26
27	Door/Heating System/Generator			1986	49,143	2,457	20	2,457		35,627	27
28	Arch Services/Call Light System			1987	109	7	15	7		95	28
29	Renovate A, B, C Wings			1987	337,164	16,858	20	16,858		227,583	29
30	Flooring D, E, F Wings			1987	29,000	1,450	20	1,450		19,575	30
31	Dietary Renovations			1987	276,810	13,840	20	13,840		186,840	31
32	Dietary Conveyor			1987	5,083	339	15	339		4,576	32
33	Dietary Refrigerator/Freezer			1987	25,083	1,254	20	1,254		16,929	33
34	ABC Wing Renovation			1988	1,521	76	20	76		950	34
35	Total from page 12B										35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 48,227		$ 47,615	$ (612)	$ 1,453,565	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Dietary Renovations			1988	815	41	20	41		512	9
10	Laundry Renovations			1989	187,559	9,378	20	9,378		107,847	10
11	Transfer Switch			1989	6,425	321	20	321		3,692	11
12	Roof Repairs/Building Repairs			1989	18,170	1,211	15	1,211		13,927	12
13	Asbestos Removal			1989	29,705		10			29,705	13
14	Sprinkler			1990	3,150	126	25	126		1,323	14
15											15
16	Lockers/Earthquake Valves			1990	9,880	494	20	494		5,187	16
17	Security System/Cubicle Tracks			1990	7,527	502	15	502		5,271	17
18	Building Improvements			1991	1,531	102	15	102		969	18
19	Asbestos Removal			1991	26,516	2,652	10	2,652		25,194	19
20	Boilers and Cooling Tower			1991	18,057	903	20	903		8,578	20
21	Medical Ancillary Center			1991	1,448	72	20	72		684	21
22	Screens			1991	1,804	120	15	120		1,140	22
23	Hazardous Waste Storage Shed			1992	1,485	75	20	75		630	23
24	Boiler & Cooling Tower			1992	289,332	14,467	20	14,467		123,217	24
25	Asbestos Removal			1992	17,956	1,796	10	1,796		13,470	25
26	Electrical Work			1992	16,098	805	20	805		6,842	26
27	Shelter			1993	7,995	400	20	400		3,000	27
28	Chain Link Fence			1993	4,990	333	15	333		2,497	28
29	Outside Lights			1993	18,839	1,256	15	1,256		9,420	29
30	Curbing & Sidewalk			1993	6,820	341	20	341		2,558	30
31	Parking Lot			1993	29,310	1,954	15	1,954		14,655	31
32	Electical Work			1993	94,220	7,086	20	4,711	(2,375)	37,354	32
33	Sealant on Building			1993	16,150	646	25	646		4,845	33
34	Paging System			1993	4,385	292	15	292		2,190	34
35	Total from page 12C										35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 45,373		$ 42,998	$ (2,375)	$ 424,707	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Casework Replacement (Built in Closets & Dressers)			1993	85,585	4,279	20	4,279		32,097	9
10	Floor Tile			1993	29,200	1,460	20	1,460		10,950	10
11	Vinyl Flooring			1993	4,999	250	20	250		1,875	11
12	Fire Doors			1993	681	34	20	34		255	12
13	Side Walk Extension			1994	4,999	250	20	250		1,625	13
14	Parking Lot-Striping			1994	1,543	103	15	103		669	14
15	HVAC System			1994	4,570	229	20	229		1,488	15
16	Boiler Room			1994	34,821	1,741	20	1,741		11,317	16
17	Floor Tile			1994	4,999	250	20	250		1,625	17
18	Masonry Work			1994	4,840	194	25	194		1,261	18
19	Sealant on Building			1994	850	34	25	34		221	19
20	Visual Observation System			1994	60,480	4,032	15	4,032		26,208	20
21	Boiler Room			1995	5,379	269	20	269		1,479	21
22	Safety Wire Glass			1995	2,600	173	15	173		952	22
23	Telephone System			1995	16,928	846	20	846		4,653	23
24	Tuckpointing & Waterproofing Stone Wall			1996	1,800	72	25	72		324	24
25	Electical Repairs			1996	5,176	259	20	259		1,165	25
26	Metal Fire Doors			1996	1,785	89	20	89		401	26
27	Shelving			1996	3,680	184	20	184		828	27
28	Fire Doors			1997	707	35	20	35		123	28
29	Carpet - Bus. Office			1998	4,047	809	5	809		2,235	29
30	Metal Fire Retardent Doors			1998	2,912	146	20	146		353	30
31	Fuel Tank Removal/Upgrade			1998	85,056	4,253	20	4,253		11,710	31
32	Side Rails			1998	2,697	180	15	180		501	32
33	Counter Top			1998	784	52	15	52		118	33
34	Shelter			1999	1,671	167	10	167		191	34
35	Total from page 12D										35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 20,390		$ 20,390	$	$ 114,624	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Patio-Hillside Nursery			1999	1,000	100	10	100		139	9
10	Chain Link Fence Extension			1999	510	34	15	34		48	10
11	Ceiling Tiles			1999	557	70	8	70		93	11
12	Patio			2000	2,612	65	10	65		65	12
13	Mini-Kitchen Unit OT			2000	3,342	158	20	158		158	13
14	HVAC Project			2000	2,039,563	0	20				14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 427		$ 427	$	$ 503	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,344,781	$ 100,535	$ 97,355	$ (3,180)	5-20	$ 895,615	37
38	Current Year Purchases	17,975	1,312	1,312		5-20	1,312	38
39	Fully Depreciated Assets	403,433					403,433	39
40								40
41	TOTALS	$ 1,766,189	$ 101,847	$ 98,667	$ (3,180)		$ 1,300,360	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 311,096	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 261,982	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (49,114)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 5,996,712	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Medical Ancillary Complex 1990	$ 107,276	$ 5,364	$ 56,322	52
53	HVAC Project	103,052			53
54					54
55					55
56					56
57	TOTALS	$ 210,328	$ 5,364	$ 56,322	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/8	hrs	$	277	$ 5,934	$ 1,552	277	$ 7,486	1
2	Licensed Speech and Language Development Therapist	39/8	hrs		452	18,076	418	452	18,494	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/8	hrs		622	10,234	753	622	10,987	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/8	# of prescrpts				144,752		144,752	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education	39/8	hrs				111,000		111,000	11
12	Exceptional Care Program									12
13	Other (specify): VA Lab,M'care lab, Tr	39/8					24,637		24,637	13
14	TOTAL			$	1,351	$ 34,244	$ 283,112	1,351	$ 317,356	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,191,398	$	1
2	Cash-Patient Deposits	37,916		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 225,000)	983,178		3
4	Supply Inventory (priced at)	4,963		4
5	Short-Term Investments	1,946,373		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	884		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from other funds, Payroll	181,482		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,346,194	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	156,054		13
14	Buildings, at Historical Cost	7,775,278		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,766,189		16
17	Accumulated Depreciation (book methods)	(6,099,871)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,597,650	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,943,844	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 131,990	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,916		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,247		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Vacation, Advanced Billing	408,946		36
37	DPA Assessment	(12,090)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 762,009	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	785,934		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 785,934	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,547,943	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,395,901	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,943,844	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,060,407	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,060,407	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(313,021)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (313,021)	17
	B. Transfers (Itemize):		
18	**Transfer to County**	(297,881)	18
19	**Transfer to Health Department**	(53,854)	19
20	**Transfer from Solid Waste Fund**	250	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (351,485)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,395,901	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,625,101	1
2	Discounts and Allowances for all Levels	(566,153)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,058,948	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	495	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,100	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,595	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	334,925	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 334,925	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Copies, Postage, Vending, Auxillary, etc.	5,341	28
28a	Misc.	2,449	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,790	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,404,258	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,578,565	31
32	Health Care	2,930,583	32
33	General Administration	1,465,473	33
	B. Capital Expense		
34	Ownership	316,460	34
	C. Ancillary Expense		
35	Special Cost Centers	283,452	35
36	Provider Participation Fee	142,746	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,717,279	40
41	**Income before Income Taxes (line 30 minus line 40)****	(313,021)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (313,021)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,088	$ 55,393	$ 26.53	1
2	Assistant Director of Nursing	1,888	2,088	46,468	22.25	2
3	Registered Nurses	36,353	38,933	647,451	16.63	3
4	Licensed Practical Nurses	27,741	30,377	406,837	13.39	4
5	Nurse Aides & Orderlies	105,121	115,082	1,262,254	10.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,363	6,611	164,620	24.90	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,832	2,088	40,675	19.48	9
10	Activity Assistants	9,076	9,856	83,872	8.51	10
11	Social Service Workers	6,617	7,229	87,752	12.14	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,088	40,529	19.41	13
14	Head Cook	34,850	37,546	352,596	9.39	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	10,200	11,188	94,182	8.42	17
18	Housekeepers	31,915	36,215	393,166	10.86	18
19	Laundry					19
20	Administrator	1,808	2,088	45,691	21.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	11,641	12,617	160,533	12.72	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	289,205	316,094	$ 3,882,019 *	$ 12.28	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 13,296	L1, C3	35
36	Medical Director	480	37,080	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		9	L10, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Quality Assessmen	12	1,350	L10, C3	46
47	Dental Consultant	480	20,616	L10, C3	47
48	Psych Consultant		2,000	L10, C3	48
49	TOTAL (lines 35 - 48)	1,068	$ 74,951		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Bad Debt Expense	$ 21,904
TOTAL (agree to Schedule V, line 17, col. 3)	$ 21,904
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Jackson County	Legal Retainer Fee	$ 15,000
Jackson County	Salary	3,360
Management Data, Inc.	Computer Support	3,730
Kerber, Eck & Braeckel	Audit/Cost Report	4,835
Immigration & Naturalization Svc.	VISA	610
Consolidated Insurance Agency	Insurance Fee	30
Health Outcomes Management	Consulting	930
American Health Care Supplies	Supplies	1,180
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 29,675

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,060
Unemployment Compensation Insurance	19,442
FICA Taxes	287,377
Employee Health Insurance	314,735
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	333,373
Employee Physicals	2,449
Employee Relations	24,208
Dental Insurance	30,057
Less Vending Income	(4,756)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,082,945

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,198
Health Care Worker Background Check	
(Indicate # of checks performed)	
Il Dept. of Nuclear Safety	21
Books & Subscriptions	2,711
CNHA & IHCA dues	10,678
Chamber of Commerce	225
Sam's Club Membership	145
HCFA Lab Prog. & Misc.	159
Less: Public Relations Expense	(840)
Non-allowable advertising	(225)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,072

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage paid to various employees for	
local travel	1,703
Seminar Expense	
and related cost for lodging and meals	7,106
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,809

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Print Preview

Facility Name & ID Number Rehab & Care Center-Jackson County # Report Period Beginning: 12/1/99 Ending: 11/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **CHNA 5339, IHCA 5339**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **17**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **142,746 Lic. Bed Tax**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Kerber, Eck & Breackel, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit in process, will send when comple**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

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